

Rule 59G-6.010, F.A.C., except as modified by this plan.

- E. Each FQHC shall file a legible and complete cost report within 3 months, or 4 months if a certified report is being filed, after the close of its reporting period. Medicare-granted exceptions to these time limits shall be accepted by AHCA.
- F. If an FQHC provider submits a cost report late, after the 90 day period, and that cost report would have been used to set a lower reimbursement rate for a rate period had it been submitted within 3 months, then the FQHC provider's rate for that rate period shall be retroactively calculated using the new cost report, and full payments at the recalculated rate shall be effective retroactively. An FQHC which does not file a legible and complete cost report within 6 calendar months after the close of its reporting period shall have its provider agreement cancelled.
- G. AHCA shall retain all uniform cost reports submitted for a period of at least 5 years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 45 CFR 205.60 (1992). Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes.

II. Audits

All cost reports and related documents submitted by the providers shall be either field or desk audited at the discretion of AHCA.

A. Description of AHCA's Procedures for Audits - General.

1. Primary responsibility for the audit of providers shall be borne by AHCA. AHCA audit staff may enter into contracts with CPA firms to ensure that the requirements of 42 CFR 447.202 (1992) are met.
2. All audits shall be performed in accordance with generally accepted auditing standards as incorporated by reference in Rule 21A-20.008 (4-21-91) F.A.C. of the American Institute of Certified Public Accountants (AICPA).
3. The auditor shall issue an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all Federal and State regulations pertaining to the reimbursement program for FQHC's. All reports shall be retained by AHCA for 3 years.

B. Retention

All audit reports issued by AHCA shall be kept in accordance with 45 CFR 205.60 (1992).

C. Overpayments and Underpayments

1. Any overpayments or underpayments for those years or partial years as determined by desk or field

audits, using approved State plans, shall be reimbursable to the provider or to AHCA as appropriate.

2. Any overpayment or underpayment that resulted from a rate adjustment due to an error in either reporting or calculation of the rate shall be refunded to AHCA or to the provider as appropriate.
3. Any overpayment or underpayment that resulted from a rate based on a budget shall be refunded to AHCA or to the provider as appropriate.
4. The terms of repayments shall be in accordance with Section 409.902, Florida Statutes.
5. All overpayments shall be reported by AHCA to HHS as required.
6. Information intentionally misrepresented by an FQHC in the cost report shall result in a suspension of the FQHC from the Florida Medicaid Program.

D. Appeals

For audits conducted by AHCA a concurrence letter that states the results of an audit shall be prepared and sent to the provider, showing all adjustments and changes and the authority for such. Providers shall have the right to a hearing in accordance with Section 59-1.021, Florida Administrative Code (F.A.C.), and Section 120.57, Florida Statutes, for any or all adjustments made by AHCA.

III. Allowable Costs

Allowable costs for purposes of computing the encounter rate, shall be determined using Title XVIII (Medicare) Principles of Reimbursement as described in 42 CFR 413 (1992), and the guidelines in the Provider Reimbursement Manual HCFA-Pub. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C. except as modified by Title XIX of The Social Security Act (The Act), this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Florida Medicaid Program. These include:

A. Costs incurred by an FQHC in meeting:

1. The definition of a federally qualified health center as contained in Section 4161(a)(2) of the Omnibus Budget Reconciliation Act of 1990 as described in Section 1861(aa)(1)(A)-(C) of the Social Security Act.
2. The requirements established by the State Agency responsible for establishing and maintaining health standards under the authority of 42 CFR 431.610(c)(1992).
3. Any other requirements for licensing under the State law which are necessary for providing federally qualified health center services.

- B. An FQHC shall report its total cost in the cost report. However, only allowable health care services costs and the appropriate indirect overhead cost, as determined in the cost report, shall be included in the encounter rate. Non-allowable services cost and the appropriate

indirect overhead, as determined in the cost report, shall not be included in the encounter rate.

C. Medicaid reimbursements shall be limited to an amount, if any, by which the rate calculation for an allowable claim exceeds the amount of a third party recovery during the Medicaid benefit period. In addition, the reimbursement shall not exceed the amount according to 42 CFR 447.321 (1992).

D. Under this plan, an FQHC shall be required to accept Medicaid reimbursement as payment in full for covered services provided during the benefit period and billed to the Medicaid program; therefore, there shall be no payments due from Medicaid recipients. As a result, for Medicaid cost reporting purposes, there shall be no Medicaid bad debts generated by Medicaid recipients. Bad debts shall not be considered as an allowable expense.

E. Change in ownership of depreciable assets. For purposes of this plan, a change in ownership of assets occurs when unrelated parties: purchase the depreciable assets of the facility; or purchase 100 percent of the stock of the facility and within one year merge the purchased facility into an existing corporate structure or liquidate the purchased corporation and create a new corporation to operate as the provider. In compliance with Section 1861 (v) (1) of the Social Security Act, in a case in which a change in ownership of a provider's or lessor's depreciable

assets occurs, and if a bona fide sale is established, the basis for depreciation will be the lower of:

- (1) The allowable acquisition cost of the facility to the first owner of record upon enrollment into the Florida FQHC Program.
- (2) The acquisition cost of the facility to the new owner; or
- (3) The fair market value of the facility at the time of purchase.

This valuation shall be used to calculate depreciation and interest on capital indebtedness.

- F. Allowable costs of contracts for physician services shall be limited to the prior year's contract amount or a similar prior year's contract amount, increased by the Medicare approved rate of increase for services rendered in the contract.

IV. Standards

- A. The initial reimbursement ceiling shall be set at \$62.48 and shall be effective from July 1, 1990 through June 30, 1991. For subsequent rate periods, reimbursement ceilings shall be established at the 80th percentile of the prospectively determined rates statewide and shall be effective from July 1 through June 30 of the appropriate year.
- B. Changes in individual FQHC rates shall be effective July 1, of each year.
- C. All cost reports received by AHCA as of April 15 of each year shall be used to establish the reimbursement

ceilings and encounter rates for the following rate period.

D. The individual FQHC's prospectively determined rate shall be adjusted only under the following circumstances:

1. An error was made by AHCA in the calculation of the FQHC's rate.
2. A provider submits an amended cost report used to determine the rates in effect. An amended cost report may be submitted in the event that it would effect a change of 1 percent or more in the total reimbursement rate. The amended cost report must be filed by the filing date of the subsequent cost report. An audited cost report may not be amended. A cost report shall be deemed audited 30 days after the exit conference between field audit staff and the provider has been completed.
3. Further desk or on-site audits of cost reports used in the establishment of the prospective rates disclose a change in allowable costs in those reports.

E. Any rate adjustment or denial of a rate adjustment by AHCA may be appealed by the provider in accordance with 59-1.021 F.A.C., and Section 120.57 Florida Statutes.

F. FQHC allowable cost relates to services defined by Section 1861(aa) (1) (A)-(C) of the Social Security Act as:

- physician services
- services and supplies incident to physician services (including drugs and biologicals that cannot be self administered)
- pneumococcal vaccine and its administration and influenza vaccine and its administration
- physician assistant services
- nurse practitioner services
- clinical psychologist services
- clinical social work services.

Also, included in allowable cost are cost associated with case management, transportation, on-site lab and on-site X-ray services.

G. Pharmacy and immunization costs shall be reimbursed through the Title XIX pharmacy program utilizing current fee schedules established for those services. These costs shall be reported in the cost report under non-allowable services, and product costs shall be adjusted out. Cost relating to contracted pharmacy services shall be reported under non-allowable services, and adjusted out in full.

H. Cost relating to the following services are excluded from the encounter rate and shall be reported in the cost report under non-allowable services.

1. Ambulance services;
2. Home health services;
3. WIC certifications and recertifications;
4. Any health care services rendered away from the clinic, at a hospital, or a nursing home.

These services include off site radiology services and off site clinical laboratory services. However, the health care rendered away from the clinic may be billed under other Medicaid programs, if eligible.

- I. Under no circumstances shall any encounter rate exceed the reimbursement ceiling established.

V. Method

This section defines the methodologies to be used by the Florida Medicaid Program in establishing reimbursement ceilings and individual FQHC reimbursement encounter rates.

A. Setting Reimbursement Ceilings.

1. Review and adjust each center's cost report available to AHCA as of each April 15 to reflect the results of desk or field audits.
2. Determine each centers' encounter rate by dividing total allowable costs by total allowable encounters. (See Section X for the definition of allowable encounters).
3. Adjust each center's encounter rate with an inflation factor based on the Consumer Price Index (CPI) of the midpoint of the center's cost reporting period divided into the CPI projected for December 31 of each year. The adjustment shall be made utilizing the latest available projections from the Data Resource Incorporation (DRI) Consumer Price Index. (Appendix A)

4. Array the encounter rates established in step 3 above from the lowest to highest and set the reimbursement ceiling at the 80th percentile of the prospectively determined rates.

B. Setting Individual Center Rates.

1. Review and adjust each FQHC's cost report available to AHCA as of April 15th to reflect the results of desk and field audits.
2. Determine each FQHC's encounter rate by dividing total allowable cost by total allowable encounters. (See Section X for definition of allowable encounters).
3. Adjust each center's encounter rate with an inflation factor based on the Consumer Price Index (CPI) of the midpoint of the center's cost reporting period divided into the CPI index projected for December 31 of each year. The adjustment shall be made utilizing the latest available projections as of March 31 for the Data Resource Incorporation (DRI) Consumer Price Index. (Appendix A)
4. Establish the prospective encounter rate for each FQHC as the lower of the prospective encounter rate established in 3. above or the ceiling established in A.4. above.